Immigrant women's health: initial clinical assessment

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This article is the first in a series of 5 articles exploring immigrant women's health. These articles are adapted from the book *Immigrant Women's Health*, published by Jossey-Bass, San Francisco, 1999.

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The medical care of recent immigrant women must reach beyond the western focus on identifying pathologic processes that cause a symptom or might lead to disease. Physicians are confronted with a variety of backgrounds and experiences, all of which may have health consequences and effects on communication, modesty, and the use of health services.

In the initial meeting with a new immigrant, the primary care physician aims to achieve the following goals:

- To understand the effects of migration on health
- To incorporate the patient's health belief system into the therapeutic relationship
- To use screening tests only when indicated
- To render necessary care and comprehensive services in a culturally competent manner.

Whether the newcomer is an immigrant or a refugee, how long she has been in this country and whether she has had prior screening should be ascertained at the first visit. Although immigrants generally have time to plan their move, refugees often have to flee their country of origin with little time to plan or to choose their destination. The flight itself can have health consequences, and refugees may have interim stays in camps under less-than-optimal conditions.[1]

Immigrants and refugees have sustained the stresses of both a move and of being newcomers to our society, with similar barriers in language and understanding of a new culture and health system. Some legal immigrants from Central America or the Middle East, for example, may not technically be refugees but have nevertheless undergone the same trauma of war and survivorship.

In general, refugee patients are at higher risk for physical and emotional crises after arrival than at other times.[2] Details of their migration experience may elicit emotional pain, so such questioning should be deferred until a later visit if they are not directly related to making a diagnosis. The clinician must also establish trust with the patient by ensuring, as much as possible, that her immigration status will not affect the care delivered.

Summary points

- Physicians and other health care providers need to understand the effects of migration on immigrant women's health
- A comprehensive review of symptoms should be performed at the first clinic visit
- The most useful initial questions are those that elicit what the patient calls her problem, the kind of treatment she thinks she should receive, and the most important results she hopes to get from treatment
- The initial assessment should include questions about income, smoking and substance use, and immunizations

Sluzki has identified 5 stages of migration (see box).[3] Many refugees will have the assistance of a social service agency or sponsor. Immigrants may have less social service support, particularly if they are undocumented persons. During the decompensation stage, refugees who have obtained only initial screening services may now return because of symptoms that may be either somatic manifestations of stress or exacerbations of chronic conditions for which they have delayed seeking care because other concerns (such as basic survival) were more pressing.

FIRST CLINIC VISIT

The initial clinic visit follows the format of the typical history taking and physical examination. It includes, however, taking a migration history and attending to any severe, acute problems.

Sean Sprague/Panos Pictures

Some legal immigrants from Central America are not technically considered refugees, but they often have undergone the trauma of war

Taking the history

The migration history is generally ascertained over several clinic visits. At the first visit, simply eliciting when the patient arrived in the United States, her current living situation, and whether she resides with family, friends, or alone may be sufficient. After the initiation of a migration history, the physician should explore any medical symptoms. It is important not to define for the patient that symptoms are either physical or emotional, a paradigm unique to western culture. Rather, a more comprehensive review of systems should be used that focuses on revealing symptoms. The clinician also should explore the patient's belief about the origin of her symptoms. Johnson and co-workers have developed an explanatory belief model that suits this purpose well (see box).[4] The most useful initial questions elicit what the patient calls her problem, the kind of treatment she thinks she should receive, and the most important results she hopes to get from treatment.

In addition to eliciting details about her living situation, the social history should include whether the patient has a means of income or assistance and information on occupation. Smoking and substance use history should also be obtained. Tobacco use by household members should be ascertained; in many cultures, women who do not smoke (and they are less likely to) and their children may have high exposure to secondhand smoke because immigrant male smoking rates are similar to or higher than those of US men. The medication history should be elicited nonjudgmentally and should include the use of herbs, alcohol, certain foods, and preparations from animal parts because, in many cultures, all of these play a role in treating illness or promoting health and strength. Many of the preparations have pharmacologic properties and can cause symptoms or cross-react with medications the physician may want to prescribe. The patient also should be asked about traditional healing methods.

Immunization records may be available for immigrants who had screening in their country of origin. Because immunization is a critical component of preventive care, when records are missing, the physician should attempt to ascertain if the patient had any immunizations as a child, whether she received a set of immunizations before coming to the United States, and when the last set was given. The patient should be asked whether she has received bacillus Calmette-Guérin (BCG) vaccine, a vaccine frequently given in Mexico, the former Soviet Russia, and Southeast Asia to prevent serious forms of tuberculosis when infection occurs.

When available, the overseas screening examination should be thoroughly reviewed during the first clinic visit, if possible. An initial screening assessment on arrival in the United States is important to detect other health problems that are not part of the overseas assessment, as well as problems that have developed since the overseas examination was performed. Many immigrants have no medical records for the physician to review. Asking whether the patient has had any screening before arrival can sometimes be a proxy for legal versus illegal immigration. It is important to try to build a history of previously received medical care and immunizations.

Women should be asked when their last menstrual period occurred and whether they think they are pregnant. These questions should be asked through an interpreter

Sluzki's stages of migration

- Planning stage–characterized by excitement, anxiety, and tension. May last hours or days
- Migration. Duration may be only a few hours or up to years if living in a refugee camp
- Overcompensation–characterized by novelty- and task-oriented adaptation. Usually lasts 6 months to 1 year after arrival
- Decompensation–characterized by acculturation and/or culture shock, loss, and mourning. Usually lasts 6 months to 1 year after arrival and may recur
- Resolution, or stage of intergenerational support–characterized by being occupied with rearing bicultural children or establishing a personal social network

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Women from Southeast Asia may have received a vaccine to prevent serious forms of tuberculosis but they often have no medical records to confirm when or where vaccination occurred

without the presence of family members. The patient should be asked if she has had previous gynecologic examinations (including Papanicolaou screening). Because refugee women may have lost children, deferring a more extensive obstetric history to another time may be more appropriate, unless it is needed for prenatal care. During the history taking, a detailed sexual history also should be elicited, including a history of rape or sexual trauma that may have occurred before or during migration.

Doing the physical examination

The initial history should direct the physician to an appropriate physical examination with attention to all major organ systems. The examination should include an assessment of vital signs (including blood pressure), skin, breasts, nutritional status, dental status, and general emotional state. Unless the patient is being seen because of a gynecologic symptom or for prenatal care, the genitourinary and rectal examinations can be deferred to a later date. This can be particularly important for immigrant women who come from cultures, such as Islamic ones, where modesty and chastity are obligatory. Honoring their beliefs can help to build a trusting relationship. On the other hand, the use of touch during the physical examination provides reassurance that the physician cares about the patient and can overcome the bounds that a language mismatch may place on a therapeutic relationship.[2]

The physical examination also offers the physician a chance to look for stigmata of folk health practices, such as moxibustion, cupping, coin rubbing, the use of special oils, and ritual scarification. At a later time, the physician may want to nonjudgmentally elicit specific information on female genital mutilation. When viewing stigmata of any folk practices, the clinician should ask for the patient's interpretation of those cultural practices and inquire whether they are for treatment, protection, or beauty. Whenever possible, the physician should accept and promote traditional practices that are safe. This will facilitate his or her ability to gradually introduce new concepts of health promotion and treatment that are more western in origin or orientation.[2]

Laboratory assessments

Many patients equate blood with life's essence and may have a great deal of anxiety about having a blood specimen drawn. The physician should explain that the body makes new blood to replace the old blood. It can be helpful to give fluids orally to symbolize replacement of the fluid that has been taken from the patient.

All necessary laboratory testing procedures should be explained to the patient. It is essential to demonstrate the importance of the laboratory portion of the examination by ensuring an in-person follow-up visit in which test results are reviewed with the patient through an interpreter. The screening protocol used by the San Francisco General Hospital (SFGH) Refugee Clinic, which was revised in July 2000, is shown in the next box. Special protocols were written for the assessment of hepatitis B, hepatitis C, and anemia (see box next page). The table shows the prevalence of hepatitis B virus carriers in the population by country of origin. Although specific laboratory protocols vary, hepatitis B virus screening has been

Questions that help to explore the patient's view of her disease or illness*

- What do you call your problem?
- What causes your problem?
- Why do you think it started when it did?
- How does it work—what is going on in your body?
- What kind of treatment do you think would be best for this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and treatment?

*From Johnson et al.[4(p157)]

Screening protocol for refugee women at SFGH Refugee Clinic*

- Complete blood cell count, urinalysis
- 3 stool specimens for ova and parasites
- Hepatitis B surface antigen (HBsAg) test if from a high-prevalence group
- Hepatitis C antibody test
- Rapid plasma reagin (RPR) test, if clinically indicated—patient has symptoms, risk factors
- Pregnancy test, if indicated
- First-stream urine specimen for chlamydia and gonorrhea
- Thyroid-stimulating hormone (TSH, or thyrotropin) test if patient is aged 50 years or older or from an area of previous radiation exposure (eg, Chernobyl, Ukraine).
- PPD skin test, updating of immunizations, Snellen vision testing, and audiologic testing

*Many patients will have had a VDRL test as part of the overseas examination for the visa; for those patients who do not have a record, an RPR test is used at SFGH for screening. Testing for HIV has often been done before arrival but might be considered in patients from East Africa and Haiti or in those who have other risk factors, if none has been documented in the past.

shown to be a cost-effective method for learning which immigrants need immunization.[5] Patients should be tested for tuberculosis with a purified protein-derivative (PPD) skin test, even if the patient has previously had BCG vaccination.

SECOND AND THIRD CLINIC VISITS

The focus of the second and third clinic visits is to review the patient's health status, results of laboratory work, and recommended interventions. The physician continues eliciting the migration history, including time of arrival and the recent past, temporally continuing from the history obtained during the first visit. The history should use the patient's words as much as possible. Refugee patients should be engaged in a discussion of health status or events that occurred in the refugee camp.

During the third visit, the physician continues to evaluate symptoms and assess the efficacy of interventions. Asking more probing questions about migration is now appropriate, such as reasons for leaving the country of origin, the status of family and friends left behind, and details of the flight. Now that the medical evaluation is underway or may have been completed, symptoms can be evaluated with a combination of traditional medical, psychological, and cultural approaches.

FORMULATING A TREATMENT PLAN

In discussing the differential diagnosis with the patient, the physician should use the words the patient has used for her symptom and illness and join this description to the western terms for the problem. Physicians also can explain their belief that western treatment with a particular agent will help this condition. In some cases, the diagnosis will be somatization of emotional symptoms, although rarely should the physician label the patient's symptoms to the patient as somatization or depression.

Discrepancies in the reporting of somatic symptoms may be due in part to the well-known correlation between socioeconomic status and health.[6] Immigrants, and especially refugees, also may be at high risk for somatization, given their recent experiences of trauma and major life changes.[7] Somatization among refugees can be considered "sociogenic,"[8] in the sense that stressful experiences lead directly to psychological distress, mental disorders, and unexplained somatic symptoms. Lin and colleagues found that Asian refugees seeking care at a Seattle health clinic used more health services than nonrefugee immigrants and were significantly more likely than nonrefugee immigrants to have vague somatic complaints.[7] Physicians should be aware that somatization can be a sign of the level of distress experienced by a patient and may be a coping mechanism.

Because of the central role of the family as the unit of care in most cultures, the physician should include the family in the treatment plan whenever possible, thereby demonstrating an understanding that illness affects all

Screening protocol for all refugees from countries where hepatitis B virus carriers are highly prevalent

- Universal hepatitis B vaccination (Hepavax) for all children aged 11 years and younger
- HBsAg testing of all refugees aged 12 years and older
- Immunization of all children aged 12 to 18 years if HBsAg test is negative
- Chronic carrier (HBsAg test is positive):
  Do liver function studies and α-fetoprotein (AFP) test
  Vaccinate household contacts: first, give first shot of Hepavax and obtain blood specimen for hepatitis B core antibody (HBcAb; second, if HBcAb test is positive, obtain blood specimen for HBsAg test and do not continue vaccination series; and third, if HBcAb test negative, continue vaccination series
- If liver function and AFP test results are normal, no follow-up needed until age 40 or new symptoms appear, then annual liver function and AFP tests
- If AFP level higher than 2.0 μg/L (>20 ng/mL), obtain right upper quadrant abdominal ultrasonogram or computed tomographic scan to assess liver, and refer to hepatologist or gastroenterologist
- If liver function test results are abnormal but AFP level is less than 2.0 μg/L, repeat laboratory tests in 6 months, and refer to hepatologist or gastroenterologist if patient is interested in treatment and treatment is indicated

Jean-Leo Dugast/Panos Pictures

Somatization, more common in refugees than in nonrefugee immigrants, may be a coping mechanism

members of a household. The physician also may inquire whether certain family members (such as the head of the household) should be present when the treatment plan is reviewed with the patient. This demonstrates respect for family and culture and improves the prospect of adherence to the therapeutic regimen.

Physicians should never use family members as medical interpreters because this confuses family roles, and most family members have little knowledge of medical terms. In addition, family members tend to "edit" the information being passed between the patient and physician in a way that might affect the patient-doctor relationship.

Because dietary manipulation is a common treatment method in most cultures, it is useful to discuss a healthy diet in relation to the patient's symptomatic complaint, in addition to prescribing medications.

PRESCRIBING MEDICATIONS

Recent immigrants may have no access to common remedies, such as over-the-counter medications, because of barriers such as language, literacy levels, and income. Prescription medications may be unaffordable if the patient has no insurance or unusable if provided with instructions in English. At the SFGH Refugee Clinic, simple symptomatic over-the-counter remedies such as acetaminophen, cough syrup, and antacid commonly are given to the patients at the initial visit, when indicated. Medication cards or instructions can be provided to the patient at the clinic, with an illustration of how to take the medicine. At some locations, commercially available computer software can be used to prepare discharge and medication instructions in various languages and at various literacy levels.

DISCHARGE INSTRUCTIONS

Whenever possible, information related to diagnosis and treatment should be delivered through a trained interpreter who ensures that all questions are relayed to the physician and answered to the patient's satisfaction and that the patient understands the discharge instructions.

VISA-MANDATED MEDICAL EXAMINATIONS

Persons who enter the United States as legal immigrants for the purpose of establishing residency will have had a medical examination in their country of origin—or, in the case of refugees, sometimes the initial country of asylum. That examination, which is used to determine whether a person should be excluded from the United States based on certain conditions, includes a medical examination, chest x-ray film, sputum smear for acid-fast bacilli, testing for the human immunodeficiency virus (HIV), serologic testing for syphilis, screening for leprosy, and screening for mental disorders.[9] "Class A" conditions, which warrant detainment, include cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, HIV infection, and leprosy. "Class B" conditions are serious ones that require follow-up but are not generally communicable (for example, diabetes mellitus, hypertension, and clinically active but not infectious tuberculosis).

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